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Notice of Independent Review Decision

DATE: 10/24/16 (11/5/16 Amended Date)

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Pre-surgical Psychological Evaluation and Testing

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is a board certified by The American Board of Neurological Surgery over 17 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who was injured on XXXX. The injury occurred while the patient was driving a XX and the XX flipped over. The claimant was diagnosed with lumbar mechanical/discogenic pain syndrome L5-S1, lumbar radiculitis, herniated nucleus pulposus L5-S1, and lumbago.

XXXXX: CT Lumbar Myelogram. Impression: 1. Grade 1 spondylolisthesis of L5-S1 with a superimposed 4mm broad posterior disc protrusion which mildly impinges upon the thecal sac, the L5 and S1 nerve roots bilaterally, but slightly greater on the left than the right. There is severe degenerative facet joint hypertrophy at this segment as well. The combination results in severe foraminal and lateral recess stenosis. Additionally, there is nonopacification of both of the S1 nerve root sheaths. 2. 2mm disc bulge at L2-L3.

XXXXX: CT Lumbar Spine with Intrathecal Contrast, Post Myelogram. Impression: There is some mild degenerative anteriolisthesis at L5-S1 secondary to relatively advanced bilateral L5-S1 facet arthropathy. There is mild narrowing and/or distortion of the L5-S1 foramina but no severe or conclusive radicular compromise is demonstrated.

XXXXXX: F/U. Patient returns for f/u after having said regimen of CT Myeolgram and evaluation for epidural steroid injections with no significant improvement in his previously described symptomology, which is marked low back pain radiating mainly into the left lower extremity along the lateral thigh and calf, and into the foot and toes on the left with associated numbness and tingling in a similar distribution. His current pain level is 8/10 on a visual analog scale with symptomology following prolonged sitting, standing, coughing, sneezing, or valsalva maneuver. Lumbar ROM restricted in forward flexion secondary to pain. Motor exam reveals 4/5 strength of the gastrocnemius muscles on the left, otherwise 5/5 throughout. Deep tendon reflexes are a +2 throughput and symmetrical. The pt

had difficulty with the toe walk and less difficulty with heel walk and tandem walk secondary to the pain. Straight leg raise was positive on the left at 30 degrees and negative on the right. Spurling's sign was negative. Sensory exams reveals a hypoesthetic region over the S1 distribution on the left to pin prick and light touch, otherwise intact. Recommendations- 1. Due to failure of conservative medical therapy including PT and ESI therapy, pain duration greater than six months, current neurologic status with evidence of the radiographic findings. I recommend- 1. Anterior lumbar interbody fusion L5-S1 with posterior lumbar decompression (to include bilateral facetectomies) with posterolateral fusion and pedicle screw instrumentation L5-S1.

XXXXX: UR. Rationale- Reasons for denial include; No literature to support the request. The requested surgery is not medically necessary so there is no reason to subject the patient to a psych eval. The pt's myelogram/CT did not show a compressive lesion- there was no nerve compromise to warrant decompression. There is no documented instability to warrant fusion, be it anterior or posterior. Spoke with XX who stated that XX noted nerve root compression at L5-S1, that conflicts with MRI report in which nerve root compression was not noted. Any film impression discrepancies should be resolved prior to any contemplated surgeries. Recommend adverse determination.

XXXXX: UR. Rationale- I am going through this carefully with XX (designated representative), she could not come up with one item that qualifies this patient for this request other than the surgeon's preference. I pointed out to her that this is not necessary and sufficient for this procedure. The request is not approved.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous adverse decision is Overturned. The patient has had persistent back and leg pain for greater than 6 months and has failed conservative therapy. The lumbar myelogram shows Grade 1 degenerative spondylolisthesis at L5/S1. There can be some difficulty seeing nerve root compromise on the CT portion of the myelogram because the anterolisthesis can suggest more space than is present for the nerves as they exit and get impacted by scarring or stretched over the slip. The patient is a candidate for a decompression and fusion for refractory back and leg pain in this instance. The anterior fusion should serve to take the disc height back to a more normal level and the realignment of L5 and S1 should relieve the nerve stretch and pressure. The posterior decompression should augment the freeing up of the nerves with the pedicle screws holding things in place while the fusion occurs. Pre-surgical psychological evaluations are very helpful and necessary for the lumbar fusion population to allow pre-surgical treatment of any psychological concerns to allow for the best outcomes and smoother recovery after surgery. Once the decision for surgery is considered, the Psychological Evaluation is part of the preoperative workup and is supported by the ODG Guidelines. Therefore, the request for Pre-surgical Psychological Evaluation is considered medically necessary.

Psychological screening	Recommended as an option prior to surgery, or in cases with expectations of delayed recovery. Before referral for surgery, clinicians should consider referral for psychological screening to improve surgical outcomes, possibly including standard tests such as MMPI (Minnesota Multiphasic Personality Inventory) and Waddell signs. However, the screening should be performed by a neutral independent psychologist or psychiatrist unaffiliated with treating physician/ spine surgeon to avoid bias. (Scalzitti, 1997) (Fritz, 2000) (Gaines, 1999) (Gatchel, 1995) (McIntosh, 2000) (Polatin, 1997) (Riley, 1995) (Block, 2001) (Airaksinen, 2006) A recent study concluded that psychological distress is a more reliable predictor of back pain than most diagnostic tests. (Carragee, 2004) The new ACP/APS guideline as compared to the old AHCPR guideline is a bit stronger on emphasizing the need for psychosocial assessment to help predict potentially delayed recovery. (Shekelle, 2008) Two factors from the adapted stress process model, *cognitive appraisal* and *emotional distress*, were identified as significant predictive factors of number of days of absence at 12 months and functional disability at 6 and 12 months. The adapted stress process model suggested that psychological variables act differently according to the variable predicted and to the period of time considered. (Truchon, 2010)

	The most helpful components for predicting persistent disabling low back pain were maladaptive pain coping behaviors, nonorganic signs, functional impairment, general health status, and presence of psychiatric comorbidities. (Chou, 2010) In workers' comp it is recommended to screen for presurgical biopsychosocial variables because they are important predictors of discectomy outcomes. (DeBerard, 2011) A shortened psychosocial screening questionnaire for workers with low-back pain, the Pain Recovery Inventory of Concerns and Expectations (PRICE), was trimmed from 129 to 46 items and remained a reliable and valid for estimating the overall likelihood of quickly recovering and returning to work within three months after injury. Among the risk subgroups, those in the one scoring high for emotional distress (e.g., for depressive symptoms, pain intensity, pain catastrophizing, activity avoidance, functional limitations and life impact of pain) were seven times less likely than those in the low- risk group to be back at work within three months. Those in the other two subgroups, high physical limitations and workplace concerns, stood only a slightly higher chance than those in the low-risk group of not being back at work. (Shaw, 2013) For more information, see the Pain Chapter, including Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients, and the Stress/Mental Chapter. See also STarT Back Screening Tool (SBST).

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**